MEDICAL HISTORY

Do you have a personal history of **ANY** of the following: ***(circle YES or NO)***

Diabetes	YES	NO	Glaucoma	YES	NO
High Blood Pressure	YES	NO			
Heart Disease	YES	NO	Pacemaker	YES	NO
If YES, explain_____			Implanted Defibrillator	YES	NO
Lung Disease	YES	NO	Artificial Heart Valve	YES	NO
Arthritis	YES	NO	Liver Disease	YES	NO
Kidney Disease	YES	NO	Artificial Joint	YES	NO
Hepatitis	YES	NO	Bleeding Disorder	YES	NO
Tobacco Use	YES	NO	Alcohol Use	YES	NO
Drug/Narcotic Habit	YES	NO	Diagnosed With HIV	YES	NO
Cancer (other than skin)	YES	NO	Anxiety	YES	NO
Type: _____	YES	NO	Depression	YES	NO
Positive TB Test	YES	NO	Hormone Replacement	YES	NO

Do you have side affects from taking antibiotics such as nausea, yeast infections, or vomiting? YES NO

Please list any surgeries with in the last 5 years:_____

_____

Do you have a personal history of skin cancer? YES NO
If yes, please explain when, what type & where: _____

Do you have a family history of skin cancer? YES NO
If yes, please list relationship to you._____

List ALL medications you are presently taking. Include aspirin or any over-the-counter medications:

_____

_____

List medication allergies (including Latex) YES NO: _____

_____

_____

Patient Signature: _____ Date:_____/_____/_____